

Regional Meetings LHD Feedback

Regions: SPHERE, Bundle, ROC, EPHRT, Northern, PACT, Mid-Ohio Valley

Below is a summary of feedback obtained by the Center for Local Health (CLH) during regional listening sessions with local health departments. The listening sessions included a power point presentation to guide the discussion and a form to capture additional comments and feedback. The comments below are presented in the same categories as outlined in the power point presentation and feedback form.

Introduction

- West Virginia Electronic Disease Surveillance System (WVEDSS), WVSIS (West Virginia Statewide Immunization Information System) and Environmental Health data are important and need to be included in the Annual Report.
- “What’s included” currently includes administrative and finance information which are important but doesn’t describe what LHDs do.

Governance and Structure

- Show WV data with smaller population categories, i.e., < 25,000.
- Assure descriptions of the cross jurisdictional sharing arrangements are accurate:
 - Threat Preparedness regions are informal regions which include MOUs specifically to support disaster response activities. All boards of health (except one) have a sub-recipient grant agreement with a Statement of Work that defines the deliverables for each local board of health jurisdiction. Each jurisdiction determines how the deliverables are carried out. The deliverables are the same for all jurisdictions regardless of the size and capacity of the agency.
 - Monroe Board of Health and Monroe Health Center, Kanawha Charleston and Putnam Boards of Health, and shared administration for Berkeley/Morgan and Randolph/Elkins.
- Summarize the geographic size (in square miles) of:
 - Each jurisdiction.
 - Regional configurations for regional epidemiologists, threat preparedness, district sanitarians, etc.
- The map of the state implies the county/municipal boards of health are organized and function similarly and they may not in terms of proposing and enforcing municipal ordinances, municipal support, and composition of the board. May be useful to analyze certain data elements specific to county/municipal boards as compared to single county boards.

Programs and Services

- 3-5 five-year trend data for programs such as family planning, breast and cervical cancer screening and immunizations would be helpful to understand trends associated with clinical services, especially in terms of the number of clinical encounters.

- The data reflects that not all local health departments provide mandated basic public health services and/or statewide programs such as threat preparedness. Local health departments shared various reasons why these discrepancies may exist and suggested the following:
 - Revise and modernize set of program codes and definitions and training to assure consistency in reporting (i.e., remove programs that no longer exist or are not provided by a significant number of LHDs) so data can be used to justify and sustain funding for local public health services.
 - Chronic disease programs/services are not reflected. Need to define LHD unique role, quantify the costs, identify funding and build capacity in this area.
 - Understand and align LHD processes with BPH reporting requirements to improve value and quality of data (timesheets, cost allocation processes for OMA and program categories).
 - Provide instructions for reporting regional program administration versus local program service delivery (WIC, Threat Preparedness).
- Environmental health activities should be included such as animal investigations, site evaluations, complaints, etc. The quarterly reports may not capture all the details in terms of 3-5 visits to resolve one complaint.
- “Clinical Encounters by Program” do not represent encounter data for all LHDs due to limited capacity of LHDs to track and report.
- Unclear what is meant by “encounter”
- “Clinical Encounters by Program” need clarification on what services entail, for example: Are immunizations in schools tracked as School Health or Immunizations? Would dental hygienists providing dental services in schools be tracked as Dental or School Health?

Community Health Assessment (CHA)/Community Health Implementation Plan (CHIP) Suggestions

- CHA template would be helpful to ensure uniformity in the quality of the assessments.
- Not much instruction/standards for CHAs, in contrast to environmental health and communicable disease.
- Implement statewide guidelines to improve the clarity and consistency of how LHDs services and resources can be used to help improve health (i.e., SSP versus addressing the problem of drug use).
- “Public health” assessment versus “community health” assessment – Balancing community support to address public health issues versus data driven approaches to address public health issues which may be more pressing.
- Include “Best Practices” that can be used by other LHDs.
- It would be beneficial if there was one community health assessment per jurisdiction that served the purposes of local health departments, hospitals, and other agencies/stakeholders, instead of repeated assessments by separate entities.

Public Health Finances

- Home Health generates a lot of revenue but also has high expenditures. Home health is a separate agency and does not support basic public health services.
- Section with more details regarding local support would be helpful (county commission, levy, municipality, etc.).
- Data does not reflect in-kind support which is critical in assuring LHDs are able to continue operating. In some cases it includes buildings, vehicles, etc.
- It would be helpful to provide a description on what is meant by revenue from “other payers.”

- A comparison to US per capita clinical revenue would be helpful in better understanding WV's per capita clinical revenue.
- Add a slide to show how clinical revenue by program compares to clinical expenditures by program.
- Would be helpful to know which programs are self-sufficient/self-supporting in terms of revenues/expenditures.
- Should include a revenue and expenditure (or expenditure) report on only basic public health services.
- Should remove "non-clinical revenue" from the "other" category and rename the form so LHDs do not include "non-clinical revenue" when reporting.
- Remove all revenue from "Other" that is identified as "non-clinical revenue".
- Data should be shown with all programs and also with programs such as home health, WIC, Dental, etc. excluded since they are not typical and not provided by a significant number of LHDs.
- Summarize LHD Environmental Fee Schedules and compare with surrounding states.
- Definitions for "classified service personnel" and "contracted personnel" would be helpful (ie, contracting with individuals and/or consultants and/or businesses or all).
- Eliminate Office, Management and Administration (OMA) as a category.

Public Health Workforce

- Include data regarding FTEs per capita, which would help agencies compare their own staffing to similar agencies within West Virginia instead of the US as a whole.

Potential Policy Areas

- Legal Guidance for Cross Jurisdictional Sharing would be helpful, ie, can a local board of health contract with another local board of health for administrative services or programs and/or service delivery?
 - Currently if someone is working independently, they must get permission from the two boards to work part-time. There is not a written agreement between the boards of health; there is an agreement between the local health department and the individual. This is a barrier because it makes it difficult for local health departments to share services.
- Every year before releasing the report, the CLH should consider visiting the association meeting to talk about the things that were discussed during the regional meetings.
- The local health departments need a niche, something they can do well to contribute and they need the expertise to do so. Harm Reduction is a great option but it's not an option for some agencies due to not having the resources to do so, both within the agency and with partners.
- Some programs generate revenue that can only be funneled back into that program (Women, Infants and Children (WIC), home health), and not into programs that do not generate revenue.
- Clear definitions are needed for Basic Public Health Programs that define LHD's role, allowable costs related to the use of state funding, and proper allocation of program expenditures.
- LHDs report that Medicaid payments are being denied because the state supplies materials for programs, or because the LHD is not in the network. If payments are received, they are minimal. LHDs reported Medicare payments are not received either.

- State guidance that supports consistent and standard approaches for addressing disparities is needed. There should be guidance on how to uniformly design and deploy interventions.
- Clear processes for appointment of local health officers, “back up health officers,” and processes to assure health officers are in place in emergency situations are needed.
- Guidance related to cost allocation for sick leave, holiday leave, lunch, etc. in terms of properly accounting for administrative costs.
- Clear definitions for all programs. LHDs may not be consistently reporting for programs; for example, hypertension may be reported as General Health in some cases, and hypertension in others.
- If an LHD wants to partner with a hospital or Federally Qualified Health Center (FQHC) on the CHA and that would cause their CHA to be done outside of the cycle of five years, would that be allowable?

Additional Comments: Finance/ Services

- Consider changing the definitions in the financial reports to improve response to questions like the number of LHDs providing programs and/or services.
- Chart of Accounts is not universal and unclear if state is participating in a uniform chart of accounts.
- The local health departments are not profiting from billing insurance.
- There is a decline of people in the offices for clinical services.
- Environmental fees should be standard and uniform across the state.
- Vaccine purchasing costs vary – different between a county ordering 10 hepatitis vaccines per month versus 200.
- Training on budget process and reporting data related to financial management is needed.
- There is no efficient way to track the work that is being done each day due to multiple job duties per person. Difficult to track what the administrator does throughout a work day and properly allocate administrative costs.
- Difficult to compete with FQHCs who receive state and federal funding. FQHCs can take patients away from LHDs.
- Some LHDs may generate environmental health revenue that doesn’t fit into permits or services. For example, tanning bed legislation passed about 3 years ago, but it’s not built into the rule for environmental permits. Some LHDs charge for this, some don’t.
- Division of Personnel, Public Employees Insurance Agency (PEIA), and retirement data systems are not talking to each other, even though they all relate to employment—and together could comprise an Human Resources department.

Additional Comments: Community Health

- Community health assessments, when done correctly, require a lot of resources. Less resourced agencies may not have the resources to maintain service delivery and conduct a quality CHA.

Additional Comments: General

- Appreciate that reports LHDs have been completing are being used to support the development of a report.
- Not getting value from the statewide calls. There has been too much change too fast. Face to face interaction is appreciated and the regional meetings are a good venue and should be continued.

- Touch base with an LHD if it seems like the data could frame a county in a bad light by the media. Felt that sometimes LHDs are put in a political position.
- “Partners” of state are not necessarily local partners, and they should be. Local health should be aware of the “partners” that CLH refers to and works with.
- President of WVALHD suggested attending WVALHD to present notes from the regional meetings.
- Desire for open-ended conversation between state and local health to talk about the ways that we need to change. There is agreement that change needs to happen, just need consensus on how that change needs to happen.
- There is difference between local autonomy and resource sharing. It sometimes feels like local autonomy is being taken away.
- Interested in having regional reports to better assess how LHDs compare to their peer LHDs.
- Resource sharing and/or regionalization can help reduce expenditures and increase capacity in some areas.
- If LHDs can meet accreditation standards, they can meet state standards.